STATE OF NEBRASKA

DEPARTMENT OF INSURANCE
L. Tim Wagner
Director

Mike Johanns
Governor

SUSPECTED FRAUDULENT CLAIM REPORT

☐ Submitted for **investigation**
☐ Submitted for **cross-referencing purposes**

Date of Preparation _____ Referring Person _____ Title _____
Name of Insurance Co./Agency _____
Address _____
Adjuster/SIU Name _____ Phone _____ Fax _____ E-Mail _____

Policy/Claim Number _____ Type of Coverage _____
(Please circle one)
Date of Loss __/__/__ Value of Claim/Loss $ _____ Has Claim Been Paid? ☐ Yes ☐ N Amount Paid $ _____
Location of Loss/Incident _____
(Complete Address) (State) (Zip)

Role _____ **Name:** _____
Business/DBA/Alias _____ Telephone _____
Address _____ State _____ Zip _____
Date of Birth _____ (M/D/Y) SSN _____ Tax I.D. Number _____
Occupation _____ Driver License Number _____ Driver License State _____
Vehicle Identification Number (VIN) _____
Vehicle Year _____ Vehicle Make _____ Vehicle Model _____ Vehicle Style _____

Role _____ **Name:** _____
Business/DBA/Alias _____ Telephone _____
Address _____ State _____ Zip _____
Date of Birth _____ (M/D/Y) SSN _____ Tax I.D. Number _____
Occupation _____ Driver License Number _____ Driver License State _____
Vehicle Identification Number (VIN) _____
Vehicle Year _____ Vehicle Make _____ Vehicle Model _____ Vehicle Style _____

Role Codes -- Please Use Additional Forms For Additional Names (Role)

CL	Claimant	BS	Body Shop	MD	Medical Doctor	MH	Medical Clinic/Hospital
CI	Both Claimant & Insured	BO	Body Shop Mgr/Owner	MC	Chiropractor	MZ	Office Administrator
CD	Claimant Driver	BE	Body Shop Employee	MA	Physician's Assistant	MM	Other Medical Personnel
CP	Claimant Passenger	LC	Lawyer for Claimant	MO	Other Doctor/Provider	MX	X-ray Lab
IC	Adjuster/Claims Personnel	LI	Lawyer for Insured	MN	Nurse	MR	Laboratory
IN	Insured	LW	Lawyer/Other	ML	Licensed Practical Nurse	MY	Medical Provider/Other
ID	Insured Driver	LR	Paralegal	MT	Physical Therapist	OP	Other Professional
IP	Insured Passenger	LO	Law Office	MS	Dentist	PH	Pharmacy/Pharmacist
A	Agent/Broker	IY	Insurance Employee	MG	Radiologist	DME	DME Supplier
ER	Employer	II	Independent Adjuster	MP	Psychiatrist	HHA	Home Health Agency
WT	Witness	IO	Other Ins. Personnel	MS	Psychologist	OT	Other

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http://www.nol.org/home/NDOI

REASON FOR REPORT CATEGORY (Check all that apply)

_____ Application fraud
_____ Inflated loss/damages
_____ Faked or exaggerated injury/damages
_____ Forged/altered/falsified documents (e.g., receipts, invoices, medical reports)
_____ Fictitious loss/damages
_____ Phony or inflated thefts
_____ Multiple claims
_____ Involved in other suspicious claims/activity
_____ Staged or caused accident/injury
_____ Property theft from vehicle
_____ Unperformed auto repairs
_____ Vehicle theft
_____ Arson (home/business/vehicle) (Circle One)
_____ Water damage
_____ Double-dipping (compensated and working)
_____ Slip and fall
_____ Malingerers
_____ Premium avoidance
_____ Prior/fake injuries
_____ Injuries unrelated to work
_____ Inflated inventory
_____ Fraudulent death claim
_____ Murder-for-profit

_____ Agent fraud (e.g., pocketing premiums)
_____ Pocketing premiums
_____ Annuity fraud
_____ Issued forged ins. policies, certificates, binders, I.D. cards
_____ Possession of forged ins. policies, cert., binders, I.D.
_____ Worthless bond
_____ Prescription tampering/abuse
_____ Billing for services not provided
_____ Billing for unnecessary treatment
_____ Upcoding
_____ Unbundling
_____ Medical charges inconsistent with services provided
_____ Hired or paid cappers to recruit clients
_____ Received compensation for referral to medical provider/attorney
_____ Misrepresentation or changes to diagnosis (ICD-9), CPT Code, dates of service
_____ Durable medical equipment
_____ Lab scams
_____ Disability fraud
_____ Money laundering
_____ Kickbacks/bribery
_____ Ring/organized activity
_____ Other _____

Identify Other Agency or Entity Where You Have Filed a Report/Complaint

Name _____
Contact Person _____

_____
(Address) (State) (Zip) (Telephone) (Fax)

Other Insurance Companies Involved? ☐ Yes ☐ No ☐ Unknown
If you answered yes above, Name of Insurance Company _____
Contact Person _____

_____
(Address) (State) (Zip) (Telephone) (Fax)

DETAILED STATEMENT

Describe the facts, which led to the filing of this report. Please attempt to put in chronological order. <u>Use additional paper if needed</u>. Attach copies of all supporting documentation.